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## Report from France

# Contemporary aspects of medical ethics in France

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### Editor's note

*The authors consider four aspects of contemporary medical ethics in France: abortion and contraception; artificial insemination; suicide and euthanasia, and drug trials on healthy human volunteers, and then outline the various ethical codes which apply to French doctors. Many in France who accept technological progress are unwilling or unable to acknowledge the impact upon medical ethics of this progress. The conflict is epitomised by the new role being demanded from the doctor. Where formerly he was regarded as the guardian of traditional values today he is urged to adapt, to change, to take account of the technological innovations in medicine. 'In such a situation,' the authors ask, 'how is it possible to avoid a feeling of uneasiness?'*

Although after World War II, France's geographical surface remained static, her population growth accelerated rapidly. Today France, with 54 million inhabitants, represents slightly less than 100 people per square kilometre. Between 1950 and 1980, life expectancy for French men rose from 63.4 to 69.1 years and from 69.7 to 77.9 years in the case of French women. These figures compare well with those of the USA (1). Similarly, in France during the last 30 years, economic expansion and the development of biomedical technology have been remarkable. Infant mortality has therefore declined. In 1960 for 1,000 children born alive in the UK the mortality rate was 22.5, in France 27.4 and in West Germany 33.8. The figures for 1978 show a general decrease in infant mortality: 10.6 in France, 13.2 in the UK and 14.7 in West Germany.

In 1980, taking the French population as a whole, its working capacity represented 23 millions of which 6 per cent were unemployed (2). Only 7.5 per cent of France's Gross National Product (GNP) is allocated for health purposes, although 98 per cent of the population is protected by Social Security and Illness Insurance. Nevertheless one peculiarity of the French health system is the coexistence of a medical public sector with a large proportion of private practices. In 1978, out of

slightly more than 100,000 practising doctors, 78,647 were free practitioners which means that they earned their living through fees. Among these 45,684 were GPs and 32,963 specialists (3).

On the level of administration organisation, French society is often quoted as an example of centralisation, which promotes a dualistic vision of France: Paris as the centre where decisions are made and the provinces which represent the suburbs. As regards the French medical profession, it is interesting to observe that this dual aspect of France shows two different characteristics. The territory is again divided in half. The Northern half has fewer doctors but these have a heavy workload and the South has more doctors with considerably less individual activity (4).

France then, situated at the Western extremity of Europe, bordering on the North Sea, the Atlantic and the Mediterranean, reveals in the composition of her medical profession, a preference for a Southern climate. In the period before the industrial revolution, France was called 'the eldest daughter of the Catholic Church'. A special, privileged relationship existed between Paris and Rome. Before World War I, the schism of 1904 between the Church and the State provoked the rupture of traditional values. And yet these values, considered through the perspective of medical ethics, affirm a structure of social stability. However, even though the technological push has given medicine greater effectiveness and greater costs, a drastic upset in the scale of values has at times helped, and at other times hindered, medical progress. This fact signifies that medical ethics has sometimes failed to keep up with technology and the changing social atmosphere both in France and in other Western countries.

Let us consider some of the contemporary ethical aspects in France by referring to four examples. These examples, though limited in number, reveal the contemporary French situation with its ambivalent concern regarding the past and the foreseeable future.

### 1. From abortion to deliberate interruption of pregnancy

In numerous countries, but perhaps especially in France due to her strong Catholic tradition, the problem of abortion created an atmosphere of deep

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### Key words

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unrest and caused an emotional division between those who desired freedom of action and those who upheld the principles of self-discipline (5). Under the pressure from these two opposing trends, the changing legal attitude towards abortion moved slowly over a period of almost 60 years, from stern disapproval starting in 1920 to final acceptance in 1979. The repression encountered at the beginning gradually yielded to an acknowledgment of the view of a high proportion of women that they should be given the possibility of interrupting undesired pregnancy.

The aftermath of World War I produced a population crisis in France which led to the passing of a law on July 31, 1920, prohibiting abortion and all users of anti-conceptual methods. The text of its articles 1, 2 and 5 condemned abortion as a crime, requiring the perpetrator to appear in court in front of judge and jury, and articles 3 and 4 denounced any form of anti-conceptual propaganda as an offence against the law.

In spite of this law and the continued practice of abortion, the court sentences were small in number. The law passed on March 27, 1923 tempered the legal attitude towards abortion, which was no longer considered as a crime but as an offence against the law, to be judged no more by a jury but by professional magistrates. The law decree of July 29, 1939 concerning the family and birth in France and subsequently the decree of May 11, 1955 warned all persons aiding or practising abortion that punishment would be either a heavy fine or imprisonment.

In reality, these laws against abortion were increasingly contested from the beginning of the sixties and more fiercely in the seventies by a number of public personalities and/or organisations (6), so that legal action against individuals became almost non-existent. In spite of a fair degree of opposition, notably from the Medical Council, the law that was passed on January 17, 1975, suspended for a period of five years all legal action against abortion provided deliberate interruption of pregnancy before the end of the tenth week was performed with the help of a doctor. This law permitted a woman faced with a situation of anxiety, to resort to an interruption of pregnancy: but the text of the law omitted to state in precise language what was considered a situation of anxiety. The law of December 31, 1979 validated completely the judicial decision of 1975, but instructed the doctor to inform the patient that abortion constituted a serious biological disturbance. Nevertheless 'the doctor is no more than a medium in helping a woman, an instrument that provides comfort and security but which is not necessarily essential, since previously women aborted without a doctor' (5).

The last obstacle concerning deliberate interruption of pregnancy was the question of reimbursement through Social Security. The Ministry of Welfare was strongly opposed to this added financial burden although a law had already been formulated and was due to be presented in Parliament. Finally this law was presented and favourably voted on at the beginning of

1983. It appears that in this case public opinion played an important part. In fact, on September 9, 1982 a Gallup poll revealed that 56.4 per cent of men and 57.8 per cent of women gave an affirmative answer to the question of reimbursement regarding interruption of pregnancy. This study shows an obvious cleavage in the opinion of the population related to age and religious feeling. For women under 25 years, 72.5 per cent gave a positive answer; 76.4 per cent between the ages of 25 and 34 gave the same answer and 57.8 per cent between the ages of 35 and 49 also gave an affirmative reply. Reimbursement was favoured by 53.4 per cent of practising French Catholics, whilst amongst those who practise little or no religion the percentage in favour of reimbursement reached 74 per cent (7).

## 2. Artificial insemination

In France for a number of years artificial insemination with sperm from other than the husband was practised in a clandestine or semi-clandestine fashion because of moral and religious opposition (8). In fact this was done by only a small number of gynaecologists in private practice. Although the technology of sperm-preservation was developed to perfection and widely used by veterinary surgeons, particularly for bovine breeding, for human artificial insemination these technologies were acquired with some difficulty.

Sperm banks were first created in Paris in 1973 (Hopital Necker and Hopital Bicêtre) (9). The demand for artificial insemination induced an equivalent increase in sperm banks – 16 in 1971; 278 in 1973; 1,344 in 1976; 2,154 in 1979 and 2,957 in 1981.

These sperm banks imposed rules regarding the use of insemination both upon the donor and the receiving couple:

- An individual donor is not financially compensated.
- A married man with children can offer his sperm only after his wife's agreement.
- A strict limit to the number of artificial inseminations from individual donors (a maximum of five children).
- The insemination only of married women if the husband is proved to be sterile or if there is a serious congenital handicap engendered through the sperm of the husband.
- Insemination can be effected only after a discussion of psychological factors with the childless couple (10).

There has been considerable progress in France regarding artificial insemination. In a resolution dated March 9, 1949, the Academy of Political and Moral Sciences took the view that 'hetero-insemination as a replacement of a husband's sterility could cause moral, legal and social disharmony in a couple, thereby precluding its use as inadvisable'.

During the parliamentary session of 1979–1980, without referring to the Chamber of Deputies, the Senate discussed a law whereby a woman could receive artificial insemination with sperm from a man other

than her husband. This insemination required a written demand from the wife and a written agreement from the husband, thus obviating a future refusal regarding the responsibilities of paternity. Reference was made to the gratuitous character of sperm donation and this text was incorporated in the Public Health Code, Chapter VI (Therapeutic use of products emanating from human origin) which actually contains only one chapter regulating the therapeutic use of human blood, and plasma. These acts come under the title of 'Donations'. It must be remembered that in France blood donors are not financially compensated.

Contrary to what has occurred in other spheres, no major differences of opinion intervened against the creation of this new technology of human insemination. The available means existing in the veterinary profession were offered to women, without the least concern or reaction from the French public. Actually, although clandestine practice has been abandoned and in spite of future possible legislation, the majority of the French population remains ignorant of sperm banks from anonymous donors.

### 3. The right to commit suicide?

According to statistics submitted by the National Institute of Health and Medical Research (INSERM), the suicide rate amounts to 10,000 each year in France. Since it is a known fact that attempted suicide is ten times this figure it can therefore be reasonably concluded that the actual number of attempted suicides exceeds 100,000 a year.

Most countries have an enormous amount of literature dealing with suicide and its prevention. In France, as in numerous other countries, organisations have been created to fight against this behaviour. The British Samaritans provide a model of these altruistic telephone-based organisations. The person contemplating suicide telephones the number of the organisation and receives from the helper words of comfort and consolation and the assurance that life is worth living. SOS Amitié (friendship) serves as an example.

In contrast to the help organisations, there exist militant groups advocating the right to suicide and some of these groups have even published brochures explaining various ways of committing suicide.

In Britain, EXIT (now the Voluntary Euthanasia Society) was established in 1935 and in 1980 its Scottish branch published a booklet entitled *How to die with dignity*.

In Holland, in 1973, the Dutch Association advocating Voluntary Euthanasia was formed. This association published a pamphlet for the use of doctors. In 1975 an Information Centre regarding Voluntary Euthanasia was created which advised its members upon methods that should be used in the case of incurable patients. Association HEMLOCK was created in the USA, an association in support of voluntary euthanasia for those with incurable diseases.

An association asserting the right to die with dignity (ADMD) was established in France in 1980. Primarily

it opposed the intervention of therapeutic aid. A general meeting of this association on May 23, 1981, decided upon the eventual publication of a guide list of advice on death with dignity. This guide lists drugs to be used for the purpose of suicide.

In 1982 a book containing 276 pages appeared in French bookshops. Its title: *How to commit suicide – history and background – technical procedures* (11). Access to this book created violent controversy amongst the public, a considerable number of people demanding its immediate withdrawal from circulation. In spite of this outburst of antagonism the book is still on sale without any restrictive measures concerning circulation. In fact a third edition is now available.

### 4. Drug trials upon healthy human volunteers

French law has no explicit clause relating to drug trials upon healthy human beings and there is no legislation forbidding it. Most lawyers, however, are against it: since there remains the possibility of risk without benefit these lawyers consider the contract formed between the investigator and the healthy volunteer as illegal (12).

Nevertheless in spite of this legal void, laboratories are forced to go through with this type of experiment in order to research the pharmacological and clinical data of a new compound. In France these experiments are carried out in a more or less clandestine manner but elsewhere, particularly in Anglo-Saxon countries, they are performed without restriction. In France these clinical trials are usually done in the public sector, either in a hospital or a university, and so far no legal action has taken place against an investigator in drug research.

The French find these clinical trials incomprehensible. The public cannot understand the usefulness of these experiments. The mass-media have on occasion represented such experiments as ethically unacceptable and have influenced the majority of the population into thinking that these trials on healthy humans are totally unnecessary.

### Ethical codes and rules

The official code of medical ethics (13,14) explains in a precise manner the duties a doctor owes to a patient. It also specifies behaviour between doctors as well as with the other health professions. Every practising doctor must have his name registered with the Medical Council.

Special rules of medical ethics are applicable to the military doctor (15): in his code professional secrecy entails revealing information, for example, that 'a pilot should not fly', to his superior officer, but this does not necessitate a doctor revealing his diagnosis. This means that the military doctor is subjected to two obligations; one to his superior officer and the other concerning his professional service.

A booklet has been written on medical ethics in public hospitals (16). A hospital doctor is considered as an agent in public service and the hospital is directly

responsible for his acts. But even though the hospital assumes this civil responsibility, like any other citizen the doctor can be sued in a court of law for failing to keep, for example, the oath of professional secrecy. Medical ethics endorse freedom of choice for a patient and also professional secrecy. Thus the head of a ward is held responsible for secrets concerning patients in the medical files entrusted to his care. But the patient does not have access to this secret information.

All these regulations represent ethical changes relevant to doctors in private practice, in public hospitals or in military service.

For the doctor who is employed by a firm, it is difficult to maintain the ethical autonomy desired by the Medical Council. This situation applies especially perhaps to doctors in the pharmaceutical industry who have registered their particular functions, responsibilities and duties in a 'charter' (17). On the basis of this charter, a set of questions put to more than 40 people in the medical and non-medical world, produced, among other conclusions, the following reflection from one of the panelists: 'In a circus what degree of independence does a clown enjoy, even the best of clowns, as compared to that of a ringmaster?' (18).

This attitude highlights one of the present problems in medical ethics: how to preserve for a salaried person in a technological society certain values derived from pre-industrial times of the 17th century which gave independent status to a doctor? Another question: how can maximum utility be brought to an ethic where the primary challenge is no longer an individual but a collective one?

Recently, a valuable paper concerning the provision of information about drugs and their side-effects was published (19) – information that is indispensable to doctors, chemists and patients alike.

To complete this picture of French medical ethics it is necessary to mention the ten suggestions formulated by Abraham Moles which could be considered as an alternative to or replacement of the Hippocratic Oath (20,21). Moles, a social psychologist, believes that the medical oath imposes no legal obligation, but that nevertheless it represents one of the principal influences exerted upon a doctor in the exercise of his profession.

To replace the old medical oath, Moles suggests ten tenets which clarify the changing behaviour of a doctor towards a more technical attitude in the contract of general care and treatment of a patient. These tenets were examined by a panel of doctors working in different branches of medical activity. Some of these tenets confirmed the change in medical ethics, whilst others provoked doubt and even hostility as in the case of the third one which stipulated that 'The doctor who hides from a patient a part of the nature of the illness and its subsequent consequences breaks his moral contract, (20). This attitude of concealment typifies French medical tradition illustrating the great difference between France and the USA.

In France, contrary to some other European countries such as Switzerland, Austria and Holland, no person can succeed in getting a doctor to break the promise of professional secrecy. Consequently in France, this secrecy is surrounded by a quasi-religious aura thereby establishing it as perhaps the cornerstone of medical morality (22).

## Conclusions

Medical ethics emanate from decisions that are taken from the moment of conception to death, and also, of course, in relation to pathological events which arise between the beginning and end of life: from conception, contraception and artificial insemination which involve life, as opposed to death in the form of abortion, suicide and euthanasia.

In France, the technological push, the changes in social structure and the increasing economic pressures enable an observer to foresee, from now to the end of the century, the changes that will occur in medical ethics. Through its relationship with philosophy, sociology, culture and law, medical ethics can be considered as a compass in the sea of social change (23).

The French display an ambivalent attitude towards technological progress. Many of those who accept this progress are either unwilling or unable to acknowledge the impact upon ethics instigated by this new medical technology. This conflict is thrown into relief by the new role demanded from the doctor. In the past he was the guardian of traditional values. Today he is urged to adapt his talent to the technical environment of social change. In such a situation how is it possible to avoid a feeling of uneasiness?

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(Continued from page 164)

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- (12) This was noted in *Curlender v Bio-Science Laboratories*. According to Kolata G B, only three of 70 couples reported decided to give birth to a child determined to have spina bifida *in utero*. See reference (9) Mass screening for neural tube defects.